



Ambridge Area School District

Central Administration Office • 901 Duss Ave. • Ambridge, PA 15003 • 724-266-2833 • 724-266-3981 fax

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Director of District Operations
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Superintendent of Schools

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Pre-K Registration Fact Sheet
2020-2021

The Ambridge Area School district will operate four PA Pre-K Counts Classrooms. The Pre-K Counts Program services three-year old and four-year old students with four-year old students having the first priority. The Pre-K Counts Program is available at each of our Elementary Schools with 20 students being the maximum capacity in each. Students are enrolled in the Elementary School closest to their geographic home regardless if they have siblings in that building or not. A student cannot be considered for enrollment without having the completed registration form AND the required documents. Once the 20 students per class has been filled, a waiting list will be established. Both breakfast and lunch are provided. Transportation is ONLY available for AASD students. This is NOT a first come first served program. Enrollment is determined through the State approved Pre-K Counts Selection Criteria.

2020-2021 Registration Information:

- Monday, February 10th: Highland Elementary (8:00 AM – 2:30 PM)**
- Tuesday, February 11th: Economy Elementary (8:00 AM – 2:30 PM)**
- Wednesday, February 12th: State St. Elementary (8:00 AM – 2:30 PM)**

Contact Person for Pre-K Registration: Cathy Hopkins 724-266-2833 ext. 1273
Call for an appointment or if you have any questions!

Required Documents at time of Registration:

- Completed Registration Document **Original** Birth Certificate
- Proof of residency Physical signed by Doctor
- Dental signed by Dentist Immunization records
- Verification of Income

Federal Poverty Level Guidelines – Annual*

Family Size	2019 – 300%
1	\$ 37,470
2	\$ 50,730
3	\$ 63,990
4	\$ 77,250
5	\$ 90,510
6	\$103,770
7	\$117,030
8	\$130,290
9	\$143,500
10	\$156,810

For additional information
Check the Ambridge Area School District website.
www.ambridge.k12.paus

**2019 Guidelines determine qualification for Pre-K Enrollment (as soon as the 2020 Guidelines are available we will publish those numbers)*

Principals: Economy Elementary: Mrs. Aphrodite Galitsis ext. 6238
Highland Elementary: Dr. Laura Burns ext. 7200
State St. Elementary: Mrs. Jo Ann Hoover ext. 4213

Proudly serving the communities of Ambridge, Baden, Economy, Harmony Township and South Heights



Ambridge Area School District 2020-2021 Pre-K Counts Enrollment Form

STUDENT DEMOGRAPHIC

First Name _____ Middle _____ Last _____

Nickname _____ Date of Birth _____ Age _____ City/State of Birth _____

Gender Male Female Ethnicity Hispanic Non Hispanic

Race American Indian/Alaska Native Asian
 Black/African American White
 Native Hawaiian/Pacific Island

Military Family: Yes No

STUDENT RESIDENCY INFORMATION (where the student resides)

Address Phone Email				
	Street	Email		
	City	State	Home Number	Cell Number
	Zip Code	Student lives with: Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____		

Borough or Township of Residence (check one)
 Ambridge Baden South Heights Homeless:
 Economy Harmony Other: _____

PRIMARY HOUSEHOLD INFORMATION (Student lives with:)

Both Mother Step-Mother Guardian

Name	
Cell Number	Employer
Email Address	Work Number

Both Father Step-Father Guardian

Name	
Cell Number	Employer
Email Address	Work Number

IF student is living with Guardian(s), please fill in this section

Name: _____ Cell #: _____ Email Address: _____ Name of biological parent: _____	Are there special custodial care instructions? Yes No <input type="checkbox"/> <input type="checkbox"/> If yes, please provide copy of court order to the School Building Principal. Please indicate: Foster Care Yes <input type="checkbox"/> No <input type="checkbox"/> Agency: _____
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Household/Family Size (required) check box:

<input type="checkbox"/> 1	<input type="checkbox"/> 4	<input type="checkbox"/> 7	<input type="checkbox"/> 10
<input type="checkbox"/> 2	<input type="checkbox"/> 5	<input type="checkbox"/> 8	<input type="checkbox"/> _____
<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9	

Household Income (required) check box:

<input type="checkbox"/> Less than \$5,000	<input type="checkbox"/> \$5,001-\$10,000	<input type="checkbox"/> \$10,001-\$15,000
<input type="checkbox"/> \$15,001-\$20,000	<input type="checkbox"/> \$20,001-\$25,000	<input type="checkbox"/> \$25,001-\$30,000
<input type="checkbox"/> \$30,001-\$35,000	<input type="checkbox"/> \$35,001-\$40,000	<input type="checkbox"/> \$40,001-\$45,000
<input type="checkbox"/> \$45,001-\$50,000	<input type="checkbox"/> \$50,001-\$60,000	<input type="checkbox"/> \$60,001-\$70,000
<input type="checkbox"/> \$70,001-\$100,000	<input type="checkbox"/> More Than \$100,000	

2019 Federal Poverty Level Guidelines 300%

Family Size	Annual	Monthly	Weekly
1			
2			
3			
4			
5			
6			
7			
8			
Each Additional			

Actual Annual Verified Gross Household (Family) Income: \$ _____

**Attach copies of documents used to verify income prior to enrollment*

Family income is at or below 300% of Federal Poverty Level (required risk factor). Consider all sources of income. See Federal Poverty Level Guidelines relative to family size (must be verified prior to enrollment)

Please include the date and the signature of parent or guardian and the staff person to document that any family who is Head Start income eligible (100% of FPL or below) has been informed of their eligibility for Head Start.

Parent Signature

Date

Staff Signature

Date

EMERGENCY INFORMATION List two local persons (other than yourself) usually available during the school day who have agreed to care for and provide transportation for your child if he/she becomes ill or injured and you cannot be reached. We will attempt to contact parents first.

Name	Relationship to Student	Telephone #
Name	Relationship to Student	Telephone #

Please list all children living in your household
birth to age 21

SIBLING INFORMATION

Sibling Name	M/F	Date of Birth	Grade/Age	School

Other Child Eligibility Risk Factor Criterion (Must check all that apply):

- Behavioral Supports:** A child who was referred to PA Pre-K Counts from an appropriately credentialed health or mental health practitioner who is not employed by the PA Pre-K Counts program; a child who is receiving mental health treatment. Additional verification beyond the interview is required.
- Child Protective Services:** A child who is a foster child, a kinship care child or receiving Children and Youth services.
- Education Level of Guardian:** Does not have high school diploma or GED or post-secondary degree.
- English Language Learner:** A child whose first language is not English and who is in the process of learning English is considered an English Language Learner.

<input type="checkbox"/>	Individualized Education Plan (IEP): A child who is currently enrolled in the Preschool Early Intervention program with an active IEP. Verification would be a copy of the IEP or other source of documentation from the parent or Early Intervention provider.
<input type="checkbox"/>	Incarcerated Parent: A child for whom one of the child's parents is currently in prison.
<input type="checkbox"/>	<p>Homeless: A child who lacks a fixed, regular, and adequate nighttime residence due to one of the following:</p> <p>A. Children who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, or camping grounds due to lack of alternate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;</p> <p>B. Children who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;</p> <p>C. Children who are living in cars, parks, public places, abandoned buildings, substandard housing, bus or train stations, or similar settings.</p>
<input type="checkbox"/>	Migrant (Non-Immigrant)/Seasonal Student: A migrant child has moved from one school district to another in order to accompany or to join a migrant parent or guardian, who is a migratory worker or migratory fisher, within the preceding 36 months, in order to obtain temporary or seasonal employment in qualifying agricultural or fishing work including agri-related businesses such as meat or vegetable processing, working in nurseries such as Christmas and evergreen trees farming.
<input type="checkbox"/>	Teen Mother: A child whose mother was under the age of 18 when the child was born.

To the best of my knowledge, the information provided is accurate. I understand that I may be asked to verify or substantiate information provided.

Parent/Guardian (Signature)

Date

Parent/Guardian Name (Print Name)

Staff Verifying Income and Risk Factors (Signature)

Date

**AMBRIDGE AREA SCHOOL DISTRICT
Certification of Residency Instructions**

This form is required **ONLY** if you and your student(s) are residing in the Ambridge Area School District but the lease or sales agreement and utility bill are not in your name.

The resident with whom you are living must complete this form. You and the resident must sign the form verifying that the information provided is correct. The form must be notarized.

In addition to the completed Certification of Residency form, the resident must also provide his/her proof of residency (copy of original lease or sales agreement and utility bill).

I do hereby certify:

The _____ family is residing with me (*resident's name*) _____

at _____
(*street, city, state, zip code*)

(*List all children and their date of birth*)

(*List all children and their date of birth*)

The child(ren) listed above is/are the (daughter/son) of (*parent's name*) _____
who permanently resides at my address in the Ambridge Area School District.

I certify that those listed above is/are bona fide residents in the Ambridge Area School District and I agree to pay all tuition that would be payable by a non-resident student if it determined that any facts in this certificate are false.

Resident's Signature

Parent/Guardian's Signature

Resident's Telephone Number

Parent/Guardian's Telephone Number

Sworn to and subscribed before me

This ____ day of _____, 20 ____

(Notary Public)

4903. False swearing

- a) *False swearing in official matters: "A person who makes a false statement under oath or equivalent affirmation, or swears or affirms the truth of such a statement previously made, when he does not believe the statement to be true is guilty of a misdemeanor of the second degree if: (2)falsification is intended to mislead a public servant in performing his official function/"*

In addition, residency may be verified by the school district's home school visitor periodically through the year and if the Ambridge Area School District discovers the fact set forth are false; it will seek restitution from the resident.

AMBRIDGE AREA SCHOOL DISTRICT
STUDENT HEALTH HISTORY

Name _____ Sex _____ Date of Birth _____ Grade _____

HEALTH CONDITIONS: check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Arthritis, type _____ | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Nosebleeds (freq.) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Birth/congenital malformations | <input type="checkbox"/> Headaches (freq.) | <input type="checkbox"/> Sinus infections (freq.) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Stool soiling |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Chicken Pox (year) | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tics/nervous twitches |
| <input type="checkbox"/> Constipation or diarrhea (freq.) | <input type="checkbox"/> Meningitis/encephalitis | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Diabetes, type _____ | | |
| <input type="checkbox"/> Other _____ | | |

Please comment on any of the above checked items:

1. Does your child have any allergies (foods, medications/drugs, bee or other insect stings, etc.): Yes No

If yes, list allergy to what, type of reaction and the recommended treatment, if any.

2. Does your child have asthma? Yes No

3. Does your child take any medication on a regular basis? Yes No

Name of medication(s) _____

Reason(s) _____

4. Has your child ever had a serious illness, injury or operation? Please describe and give dates.

5. Does your child have any vision problems? _____ wear glasses/contacts _____

6. Does your child have any hearing problems? _____

7. Are there any other health problems (physical or emotional) you feel we should be aware of _____

8. Additional comments _____

Parent/Guardian Signature _____ Date _____

The above information will be reviewed and other forms will be sent to you if additional information is required.

Ambridge Area School District Medical Information Authorization Form

In order to comply with federal and state laws, the Ambridge Area School District requires that this form be completed in its entirety.

I authorize Kristine McCloskey, Kathy Meder, Sharon Kilmer, Stuart Rusnak, Rebecca Sheline and/or any School Nurse from the Ambridge Area School District to use/disclose the following Protected Health Information from the records of:

Individual/Student Name

Date of Birth

as described below to: Any other AASD teacher or staff member, including substitutes, building principals and secretaries who may be responsible for my child.

The information is requested for the purpose of: To inform any such staff member or administrator who may be responsible for my child of any serious medical conditions, allergies, medications and/or emergency contacts.

The information to be used/disclosed is identified as follows (please check all that apply):

Medical History & Physical Exams

Psychiatric/Psychological Evaluations

Occupational Therapy

Physical Therapy

IEP

ER's

Discharge Summary/Instructions

Immunization Records

Physician Orders

Verbal Information

Other (please specify): Any health information appearing on the Student Emergency Information Card submitted to the School Nurse regarding serious medical need/conditions, allergies, medications, emergency contacts or health insurance.

I understand the following:

- That the information used or disclosed may include records relating to my identity, diagnosis, prognosis and treatment;
- That the information used or disclosed may relate to psychiatric disorders, drug and/or alcohol use, AIDS and HIV, as the same are permitted by the Mental Health Procedures Act, the Confidentiality of Alcohol and Drug Abuse Individual Records Act, the Confidentiality of HIV-Related Information Act and the Privacy Rule of the Health Insurance Portability and Accountability Act;
- That I have the right to revoke this authorization at any time, except to the extent that Ambridge Area School District has already acted in reliance on the Authorization and that such

revocation must be made in writing and directed to the Privacy Officer, Superintendent, Dr. L. Joan Welter;

- That the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law;
- That Ambridge Area School District may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization, except as provided by law; and
- That if the Ambridge Area School District seeks this Authorization for the use or disclosure of Protected Health Information, the district must provide me with a copy of the signed Authorization.

Date

Signature of Individual/Student

Date

Signature of Parent/Legal Guardian/Personal Representative

Print Name

Specify Relationship/Authority

Home Language Survey*

Economy State St. Highland MS SH Date: _____

Student Name: _____

Date of Birth: _____ M F Grade: _____

Home Phone: _____ Cell Phone: _____

*The Civil rights Act of 1964, Title VI-Language Minority Compliance Procedures, requires that school districts/charter schools identify limited English proficient (LEP) students. Pennsylvania Department of Education has selected the Home Language Survey as the method for the identification.

What is the students first language? _____

Does the student speak a language other than English? Yes No

If yes, please indicate language; do not include languages learned in school.

What languages are spoken in your home?

Has the student attended any U.S. schools in any three (3) years during his/her lifetime?

Yes No If yes, please complete the following:

Name of School	State	Dates Attended
_____	_____	_____
_____	_____	_____
_____	_____	_____

U.S. Entry Date: _____

Name of person completing this form (if other than parent/guardian): _____

Parent/Guardian Signature: _____ Date: _____

****ONLY complete if it is determined your child is an "English as a second language student" ****

**English as a Second Language
Student Background
Questionnaire**

Student's Name: _____

Native Language: _____ Native Country: _____

Parent's Name: _____ Cell Phone: _____

Names/ages of siblings: _____

English speaking contact (if needed): _____

When did this student come to the United States? _____

What language is used with parents? _____ With siblings? _____

With friends? _____

Can student read home language? No Easy words Easy sentences Yes

Can student write home language? No Easy words Easy sentences Yes

Can student understand English? No Easy words Easy sentences Yes

Can student speak English? No Easy words Easy sentences Yes

Can student read English? No Easy words Easy sentences Yes

Can student write English? No Easy words Easy sentences Yes

If student studied English:

How long? 1 year or less 1-2 years 3-4 years more

How often? Once a week 2-4 times a week 5 or more

Class lasted? 45 minutes or less 45 minutes-1 hour more



AMBRIDGE AREA SCHOOL DISTRICT
ACCEPTABLE USE POLICY
2020-2021

ACCEPTABLE COMPUTER AND NETWORK USAGE

All use of the Internet and computer technology must be in support of the educational program within the Ambridge Area School District. The following activities are specifically prohibited and if performed will subject the user to loss of access, disciplinary action, and/or legal actions:

- The Internet and computer technology will not be used for illegal activity, for profit purposes, non-school related activities, lobbying, advertising, to transmit offensive materials, hate mail, discriminating remarks, or to obtain obscene or pornographic material.
- Users shall not intentionally seek information, obtain copies of, or modify files, other data, or passwords belonging to other users, or misrepresent other users on the network.
- Use of school technology or Internet for fraudulent or illegal copying, communication, taking or modification of material in violation of the law is prohibited and will be referred to appropriate authorities.
- Loading or use of unauthorized games, programs, files or other electronic media is prohibited.
- The illegal use of copyrighted material is prohibited.
- The network shall not be used to disrupt the work of others. Hardware or software shall not be destroyed, modified, relocated, or abused in any way.

INTERNET AND EMAIL

Students at AASD will be using various Internet resources in support of the curriculum. AASD will expect suitable online behavior, including appropriate interaction with other individuals on social networking websites and email. Internet and email activity may include, but are not limited to:

- Researching curriculum
- Responding to and commenting on curriculum projects
- Creating written / media projects and commenting on each other's work
- Collaborating on projects
- Creating content pages on curriculum topics
- Discussing or enhancing understanding of subject matter online

NETWORK ETIQUETTE AND PRIVACY

Students at AASD will abide by the generally accepted rules of network etiquette. Communication with others should always be course-related. Students should notify the teacher of anything inappropriate or that makes them feel uncomfortable. Bullying will not be tolerated and the privacy of others should be respected at all times. These rules may include, but are not limited to:

- All users will be respectful in their postings and edits. No inappropriate language, personal insults, profanity, spam, racist, sexist or discriminatory remarks, or threatening comments will be tolerated.
- No user may post, comment, or change settings on the site in violation of these terms and conditions.
- No student may edit or delete the work of another student without teacher permission.
- No student will reveal their home address or personal phone number, (or the addresses or phone numbers of other students), or any other personal information/images in any email correspondence or in any files that are shared with anyone outside of the school community.

- All students will receive a login and password to be used only by the student. If any user suspects that a password has been compromised, he/she must notify the technology department immediately.
- All use of these Internet resources must be in accordance with the school's Acceptable Use Policy, including entries made from computers outside of school.
- No posting or edit may facilitate or promote illegal activity, either overtly or by implication.

SUPERVISION AND MONITORING

AASD administrators and their authorized employees monitor all information technology resources to ensure that student utilization is secure and conforms to this policy. Administrators reserve the right to examine, use, and disclose any data found on the school's information networks in order to further the health, safety, discipline, and/or security of any student or other person, or to protect property. They may also use this information in disciplinary actions and will furnish evidence of crime to school officials and law enforcement. Teachers will make every reasonable effort to monitor conduct in order to maintain a positive learning community. All users will respect each other's time and efforts by supporting the same positive approach.

CONSEQUENCES FOR VIOLATIONS

Failure to comply with district Acceptable Use Policies may result in disciplinary action by faculty and/or administration including the loss of use of the school's information technology resources and possible referral to law enforcement agencies.

Note: This Acceptable Use Policy shall be enforced in conjunction with Board Policy 815: Acceptable Use of the Internet, Computers and Network Resources

This agreement will be in effect for the current school year only and must be re-signed every year.

"I have reviewed and explained the Acceptable Use Policy with my child."

Student Name (please print): _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

"My child has my permission to access the Internet."

Student Name (please print): _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

"As parent/guardian, I grant my child permission to use school computers on an independent basis as outlined in the Computer and Internet Usage Policy. I agree to assume responsibility for damages (hardware/software) resulting from deliberate or willful acts by my child."

Student Name (please print): _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

AASD reserves the right to publish student photographs and/or work to the district website. AASD may display and share electronically via the internet and/or in other displays, photographs and/or video footage of my child taken in conjunction with school activities. If you do not want your child to be published you must submit a request in writing to your building principal.



AMBRIDGE AREA SCHOOL DISTRICT

OFFICE 365 STUDENT ACCOUNT INFORMATION

2020-2021

Ambridge Area School District has the ability to create accounts for all students to allow for collaboration using our custom implementation of Office 365. These accounts will be used for school related projects. The rules governing proper electronic communications by students are included in our Acceptable Use Policy. Once accounts are assigned, students will gain access to Office Online (Word, Excel, PowerPoint, OneNote, Sway, and OneDrive for storage).

The primary purpose of the student Office 365 system is for students to communicate with school staff, use outside resources related to school assignments, to provide a method for students to collaborate with fellow students on school activities, to provide all students access to Microsoft Office 2016 software on a maximum of 5 computers and 5 mobile devices, and to provide access to 1TB of cloud storage that will allow students to have access to files both at home and at school. Account usernames and passwords will be provided to parents upon request so parents may monitor the account. Use of the school's Office 365 program is a privilege, and may be revoked at any time for misuse.

Official student email addresses will be assigned. This account is considered the student's official AASD email address until such time as the student is no longer enrolled at AASD. The naming convention will be the student's unique ID and password. This is the same username and password that the students use to log in to the network at school followed by @ambridgearea.org. For example, 16jasmith68@ambridgearea.org. All students should already know their usernames and passwords. If they do not, they should contact their homeroom teacher or the technology department.

Administration reserves the right to access and review student content in Office 365 at any time. AASD complies with all state and federal privacy laws. As with any educational endeavor, we feel that a strong partnership with families is essential to a successful experience.

"As parent/guardian, I grant my child permission to use the district assigned Office 365 apps and email account."

Student Name (please print): _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

01-24-20

Ambridge Area School District
Transportation Office
901 Duss Avenue
Ambridge, PA 15003

Bus Rider Registration Information

Welcome to the Ambridge Area School District!

To maintain a high level of safety for bus riders, the Transportation Department has implemented a bus rider registration procedure.

Even if you do not need transportation, please complete this form.

Thank you for your assistance and cooperation.

Name of Student: _____ Telephone No.: _____

Address: _____ Alternate No.: _____

If there is another adult who is authorized to receive a student at the bus stop, please provide his/her name and telephone number: _____

If you will require transportation from a babysitter/daycare, please be advised of the following: The babysitter/daycare must be located within the Ambridge Area School District and on an established route to/from your child's school.

Babysitter/Daycare: _____

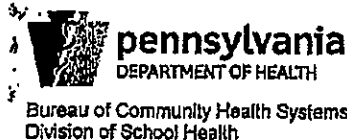
Address/Telephone: _____

Will your child require transportation from a babysitter/daycare both ways? _____

If not, please specify pick-up/drop-off arrangements: _____

PLEASE LIST BROTHERS/SISTERS – GRADE/SCHOOL: _____

*NOTE: To balance classroom size, it may be necessary to assign a student to a building based on enrollment and not residence address.



**Private or School
PHYSICAL EXAMINATION
OF SCHOOL AGE STUDENT**

PARENT / GUARDIAN / STUDENT:
Complete page one of this form before
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____
Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)
 Medicines Pollens Food Stinging insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student?</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other: _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student?</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student?</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student?</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student?</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student?</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL: <i>Has the student?</i>	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student?</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH: <i>Has the student?</i>	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/allergy problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other: _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS: <i>Has the student?</i>	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION
 (Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20__

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record - OR - insert information below.

IMMUNIZATION EXEMPTION(S):

Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20__

NAME OF CHILD			AGE	SEX	GRADE	SECTION/ROOM
_____	_____	_____		<input type="checkbox"/> M <input type="checkbox"/> F		
Last First Middle						

ADDRESS _____

No. and Street _____ City or Post Office _____ Borough or Township _____ County _____ State _____ Zip _____

REPORT OF EXAMINATION

	TOOTH CHART																	
	RIGHT								LEFT									
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
UPPER				A	B	C	D	E	F	G	H	I	J	K	L	M	N	Upper
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		Lower
UPPER																		Upper
LOWER																		Lower

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address



Ambridge Area School District Policy for Homeless Students

The Ambridge Area School Board recognizes its obligation to ensure that homeless students have access to the same educational programs and services provided to other district students. The Board shall make reasonable efforts to identify homeless children within the district, encourage their enrollment, and eliminate existing barriers to their attendance and education, in compliance with federal and state law and regulations.

The Board may waive policies, procedures and administrative regulations that create barriers for enrollment, attendance, transportation and success in school of homeless students.

Homeless students are defined as individuals lacking a fixed, regular and nighttime residence, which include the following conditions:

- Sharing the housing of other persons due to loss of housing or economic hardship.
- Living in motels, hotels, trailer parks or camping grounds due to lack of alternative adequate accommodations.
- Living in emergency, transitional or domestic violence shelters.
- Abandoned in hospitals.
- Awaiting foster care placement.
- Living in public or private places not designed for or ordinarily used as regular sleeping accommodations for human beings.
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, transportation stations or similar settings
- Living as migratory children in conditions described in previous examples
- Living as school age unwed mothers in houses for unwed mothers if they have no other living accommodations.

School of origin is defined as the school the student attended when permanently housed or the school in which the student was last enrolled.

The district's homeless liaison shall coordinate with:

- Local service agencies that provide services to homeless children and youth and families.
- Other school districts on issues of records transfer and transportation.

- State and local housing agencies responsible for comprehensive housing affordability strategies.

The district's liaison shall provide public notice of the educational rights of homeless students in schools, family shelters, and soup kitchens.

Students shall not be discriminated against, segregated nor stigmatized based on their status as homeless.

Enrollment/Placement

The selected school shall immediately enroll the student and begin instruction, even if the student is unable to produce records normally required for enrollment pursuant to district policies. However, the district may require a parent/guardian to submit contact information. The district liaison may contact the previous school for oral confirmation of immunizations, and the school shall request records from the previous district, pursuant to Board policy.

If the district is unable to determine the student's grade level due to missing or incomplete records, the district shall administer tests or utilize appropriate means to determine the student's placement.

If a dispute arises over school selection or enrollment, the student shall be immediately enrolled in the school in which enrollment is sought, pending resolution of the dispute. The parents/guardians shall be provided with a written explanation of the district's decision, their right to appeal and the procedures to use for the appeal.

Services

Homeless students shall be provided services comparable to those offered to other district students including, but not limited to, transportation services; school nutrition programs; vocational programs and technical education; preschool programs; programs for students with limited English proficiency; and educational services for which students meet eligibility criteria, such as programs for disadvantaged students, students with disabilities, and gifted and talented students.

Transportation

The district shall provide transportation for homeless students to their school of origin or the school they choose to attend within the school district.

If the school of origin is outside district boundaries or homeless students live in another district but will attend their school of origin in this district, the school districts shall agree upon a method to apportion the responsibility and costs of the transportation.

Any questions, please contact the District's Homeless Liaison Mrs. JoAnn Hoover Principal at Highland Elementary at 724-266-2833 ext. 4213.